STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120791-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17TH day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 22, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 29, 2011.

The Petitioner is enrolled for health care coverage through a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). Her benefits are defined in BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on May 10, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On December 21, 2010, the Petitioner cut fingers on her left hand. She went to the XXXXX Hospital emergency room in XXXXX, New Jersey. The staff of the hospital contacted a hand surgeon to treat her. The surgeon did not participate with either BCBSM or the local Blue

Cross Blue Shield (BCBS) plan. "Nonparticipating provider" is defined in the certificate as "[p]hysicians or other health care professionals . . . that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full."

The amount charged by the surgeon and the amount paid by BCBSM is set forth in the following table:

Procedure Code	Procedure	Amount Charged	Amount Paid	Balance
26418	Repair Finger Tendon	$1,800.00	$896.60	$903.40
12042	Intermediate Wound Repair	$570.00	* $0.00	$570.00
99284	Emergency Department Visit	$550.00	$186.06	$363.94
Total		$2,920.00	$1,082.66	$1,837.34

* This procedure is considered to be in procedure code 26418.

The Petitioner was unhappy with the amount BCBSM paid for the surgery and appealed BCBSM's determination through its internal grievance process. BCBSM held a managerial-level conference on March 9, 2011, and issued a final adverse determination on March 25, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the surgeon's care provided on December 21, 2010?

IV. ANALYSIS

Petitioner states she had to have surgery immediately because of the extensive bleeding and danger of infection. Her doctors could not wait until the following day to find an in-network surgeon. The Petitioner had no choice in the physician who performed her surgery.

The Petitioner argues that BCBSM should be required to pay an additional $1,253.34, which is the difference in the amount paid by BCBSM and 80% of the amount charged by the surgeon.

BCBSM argues that it paid its approved amount for the covered services provided the Petitioner by a non-participating provider in accordance with the terms of the certificate. Further, in accordance with the terms of coverage, because two surgical procedures (12042 and 26418) were performed by the same physician on the same day, the claim was processed according to national standards which require that procedure code 12042 (wound closure) is included in procedure 26418 (repair of finger tendon).

Page 4.3 of the certificate explains what the surgical fee includes:

> **PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**
>
> **Surgery**
>
> Payment includes:
>
> - Physician's surgical fee
> - Medical care provided by the surgeon before and after surgery while the patient is in the hospital
> - Visits to the attending physician for the usual care before and after surgery

Under the certificate, the least out-of-pocket expense is incurred if services are received from providers who participate with BCBSM or a local BCBS plan. The certificate (page 4.33) describes the possible consequences if an enrollee uses a nonparticipating provider:

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> * * *
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate (p. 4.2) also explains that BCBSM's payment is based on its "approved amount" for each covered service. "Approved amount" is defined in the BCBSM certificate as "[t]he lower of the billed charge or our maximum payment level for the covered service. . . ."

BCBSM pays its approved amount to both participating and nonparticipating providers. However, participating providers have entered into a contractual agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM's enrollees. In contrast, nonparticipating providers have no contractual obligation to accept the approved amount as payment in full and may bill a BCBSM member for any balance over BCBSM's approved amount.

As the Petitioner discovered, BCBSM's approved amount was considerably less than the surgeon's charge. If the surgeon had participated with BCBSM or the local BCBS plan, he would have accepted BCBSM's approved amount as payment in full and could not have billed the Petitioner for the difference between his charge and the approved amount.

The certificate requires BCBSM to pay only its approved amount for covered services. It does not guarantee that more will be paid to a nonparticipating provider even if the surgery was done on an emergency basis or no participating provider was available.

The Commissioner concludes that BCBSM covered the surgeon's services correctly under the terms and conditions of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of March 25, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's surgery performed on December 21, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.